Revised April 22, 2004

Nature of Problem and Resolution	Types of Medicaid Providers Effected	Date Problem was Fixed	Action that needs to be taken (if any) by Provider for Resolution
DMAS will re-institute the allowance of 20 days to receive requested medical records for pended claims. Claims where the medical records are not received in the allowed 20 days will be denied for medical records not received or, if the claims are ER, they will be reduced to the appropriate payment.	*Medicaid Enrolled Hospitals*	*05/01/2004*	*Policy will go into effect for claims received on or after May 1, 2004*
Procedure Code E1390 RR was denying incorrectly for lack of a prior authorization. This change will be reflected in the next Manual Update	*Medicaid Enrolled Durable Medical Equipment Providers*	*04/19/2004*	*No action needed. The claims effected Were reprocessed by DMAS*
Medicare Cross Over claims were incorrectly denying for reason code 0147	*Medicaid enrolled Providers submitting cross-over claims*	*04/13/2004*	*No action needed. Claims were recycled on 04/13/2004*
Medicare Part B and Part A cross-over claims were incorrectly denying for reason code 0313.	*Medicaid enrolled Providers submitting cross-over claims*	*04/09/2004*	*No action needed. Claims were recycled on 04/09/2004*
Some Medicare cross-over claims were denying incorrectly for reason 0313 (Bill any other available insurance).	*Virginia Medicaid Providers submitting Medicare cross-over claims*	*04/02/2004*	*No action needed. Claims were recycled by DMAS during the week of 4/30/2004. See remittance advice message of 4/9/2004*
Some Virginia Medicaid Providers who submitted Claims using the National Standard Format (NSF) incorrectly received denial edits 0089 and 0961 for their claims submissions.	All Virginia Medicaid Providers using the NSF EDI claims submission format	03/19/2004	No action needed. Claims were Recycled by DMAS on 3/19/2004
Some Virginia Medicaid Providers had money Incorrectly retracted through the DMAS "Claim Check" Auditing software for reason codes 1093 and 1096. These codes should have been excluded from "Claim Check" review.	Medicaid Enrolled Physicians	03/19/2004	No action needed. Claims will be Recycled by DMAS and the adjustments will appear on the 3/26/04 Remittance.
Hospital Claims were incorrectly denying for reason 919 – "Inpatient Versus Nursing Home – possible duplicate" even though the patient was correctly discharged from a Nursing Home. Edit has been temporarily removed	Medicaid Enrolled Hospitals and Nursing Homes	02/07/2004	Providers will need to resubmit their Claims submitted prior to 2/6/04
DME code K0532 Respiratory Assist Device will Be ending as of March 31, 2004. The new code will Be E0470. All claims will dates of services after 4/01/2004 will need to use the new code E0470.	Medicaid Enrolled Durable Medical Equipment Providers	04/01/2004	Use the Correct Procedure Code
Some Medicaid Providers billing EDI (electronic data Interchange) claims had claims Pend/Deny for reason 0089 – "Service Center Not Authorized to bill Medicaid." Edit 0089 has been temporarily removed.	Medicaid Enrolled Providers submitting EDI Claims	02/25/2004	No action needed. Claims will be Recycled by DMAS
Some Inpatient Medicaid claims reimbursed through the DRG payment methodology were denying incorrectly for Grouper edit #0899. This edit has been fixed.	Medicaid Enrolled Inpatient Hospitals	01/22/2004	Providers who received this denial will need to resubmit their claims
Virginia Medicaid providers who submitted claims adjustments using the old (pre-VAMMIS implementation) reference numbers were unable to adjust their claims.	All Medicaid Enrolled Providers submitting adjustments for claims processed prior to VAMMIS implementation on 06/13/2003	01/19/2004	Providers will need to resubmit their claims adjustments.
Medicaid Assisted Living claims were pending incorrectly for pend reason 0827- " unable to assign object code".	All Medicaid Enrolled Assisted Living Providers	12/16/2003	No action needed. Claims have been recycled by DMAS
Additional lines were added to the internet based automated response System (ARS). Response rates after the expansion of the system's capacity have reached 100%.	All Medicaid Providers	11/14/2003	No action needed
Some Temporary Detention Order (TDO) Hospital claims were incorrectly being approved at "0" dollars.	Hospitals Providing TDO Services	12/3/2003	No action Needed. These claims have been adjusted and the adjustment will be reflected on the 12/5/03 Remittance Advice.
The claims processing system was incorrectly processing multiple page UB-92 claims submissions	All Medicaid Providers billing multiple page UB-92 claims	12/5/2003	No action needed. Claims have been Held and will be resubmitted.
Hospital and Nursing Home Providers were receiving	All Medicaid Enrolled	12/5/2003	If the Provider Claim was denied

incorrect claim denials for edit reason 267 – "Review Medicare Part A Coverage" when the patient had only Medicare Part B. This edit has been removed for Hospitals and Nursing Homes.	Hospitals and Nursing Homes		for edit reason 267, claim will need to be resubmitted by the provider
CMS-1500 Claims submitted using a Coordination of Benefits Code (COB) 5 were being incorrectly changed to COB code 2 and, as a result, were being incorrectly denied with an incorrect reason code.	Medicaid Providers billing with The CMS-1500 Claim Form	10/07/2003	Providers will need to resubmit the claims effected.
The Automated Voice Response System (MediCall), the web-based response system and the swipe card for determining eligibility, check, claims and prior autho status has been modified to provide the name of a Medicaid client's assigned Primary Care Physician effective November 10, 2003.	All Medicaid Providers	11/10/2003	No action needed.
Edit 1148 (16 hour per day limit) was incorrectly applied to procedure codes Z9405, Z9406 and their HIPAA compliant companion codes T1030 and T1031. This edit was removed effective on November 5, 2003.	Medicaid Durable Medical Equipment Providers	11/05/2003	Provider will need to resubmit the claims affected.
A new user's manual for the internet based Automated Response System (ARS) has been posted to the DMAS web site at www.dmas.state.va.us under the "what's new" section of the web site. The internet based ARS can be used to verify eligibility, check status, claims status and prior authorization status information.	All Medicaid Providers	10/29/2003	No action needed.
Some laboratory claims were incorrectly denying for edit reason 480, even though the provider was CLIA Certified. The claims that denied for edit Reason 480 were reprocessed correctly on October 29, 2003	Medicaid Laboratory Providers	10/29/2003	No action needed.
The required use of National Standard Codes instead of Virginia Medicaid specific codes (local codes) has been delayed until December 31, 2003. This change is a result of an extension by the Federal Government of the Health Insurance Portability and Accountability Act (HIPAA). In addition, National Standard Format (NSF) Electronic data Interchange (EDI) for electronic claims submission to DMAS can continue to be used until December 31, 2003 as result of the extension of HIPAA.	All Medicaid Providers Submitting Local codes And All Medicaid Providers using the NSF EDI format for electronic claims submissions.	10/21/2003	No action needed
Providers lacked sufficient access to the internet based eligibility verification system. DMAS will add 24 additional lines to its internet Based eligibility system on September 29th.	All Medicaid Providers	9/29/2003	No action needed.
Turn around documents (TAD) identifying pended claims for emergency room services were not allowing providers sufficient time to respond before the claim automatically denied. The Response time for TADs has been extended from approximately 2 weeks to 45 days.	All Medicaid Providers submitting emergency room claims.	9/24/2003	No action needed
Outpatient Medicaid claims were denying for Edit 0821 (greater than 1 day) incorrectly. Edit 0821 was removed.	All Medicaid Providers submitting claims for outpatient services	9/2220/03	Provider will need to resubmit the claims affected.
The claims processing system was not recognizing the prior service limit of 26 visits for outpatient psychiatric services. These services were requiring prior authorization after 5 visits instead of 26 visits. After implementation, only 5 visits are allowed before authorization is required. This problem has been fixed.	All providers providing Outpatient Psychiatric Services.	9/16/2003	Claims need to be resubmitted by Provider
The claims processing system was not recognizing the prior service limit of 24 visits for occupational therapy, speech therapy and physical therapy. These services were	All providers providing Occupational therapy, Speech Therapy, and Physical Therapy	9/16/2003	Claims need to be resubmitted by provider

requiring prior authorization after 5 visits instead of 24 visits. After implementation, only 5 visits are allowed before authorization is required. This problem has been fixed.			
Providers were being incorrectly overpaid for their claims for Medicare/Medicaid patients. These claims were being "crossed over" to Medicaid and processed without accounting for the Medicaid payment limit for the service provided.	All Medicaid Providers Submitting claims to Medicaid for recipients enrolled in Medicare, with Medicaid as a secondary payor.	9/16/2003	No action needed. Claims will now be correctly processed. DMAS will determine how these incorrect payments will be recovered from providers within the next several weeks.
HCFA 1500 Claims submitted by providers were incorrectly pending with individual consideration reason "0209" if a modifier 22 was placed on the claim **or** an attachment was included with the claim. This edit has been modified to pend for Individual Consideration, only if both the modifier 22 **and** an attachment are with the claim.	All Medicaid providers submitting HCFA 1500 claims with a Modifier 22 or an attachment	9/16/2003	Provider will need to resubmit the claims affected.
Dental claims were incorrectly being denied for surface codes "B" and "I". The claims processing system has been corrected to except all valid surface codes.	Dental Providers	9/15/2003	Provider will need to resubmit the claims affected.
Procedure Codes 92012, 92014, 92015 Incorrectly contained an edit that limited the use of the procedure code based on the age of the enrollee. This edit has been removed.	All Providers billing these procedure Codes after June 20, 2003	9/12/2003	Claims affected by this problem must be resubmitted by the provider.
The "Units/Visits/Studies (UVS) for procedure code A4253 was set to "2" incorrectly. The UVS should have been set to "3". UVS is now correct.	Durable Medical Equipment Providers (DME)	9/01/2003	Claims need to be resubmitted by provider
The UVS for procedure code A5061 was set to "1" incorrectly. The UVS should have been set to "15". The UVS is now correct	Durable Medical Equipment Providers (DME)	9/01/2003	Claims need to be resubmitted by provider
Prior authorization requests for orthodontic services submitted on an American Dental Association (ADA) paper claim form were not being generated correctly, denying the Prior Authorization request. This process has now been fixed.	Orthodontists	9/01/2003	Provider will need to re-submit their prior authorization request for any outstanding, non-approved request.